

# **EXHIBIT B**

**Jeffrey Bomber, D.O.**

**05/28/2021**

1       IN THE UNITED STATES DISTRICT COURT  
2       FOR THE EASTERN DISTRICT OF MICHIGAN  
3               SOUTHERN DIVISION

4

5

6   KOHCHISE JACKSON,               Case No.:

7                               2:19-cv-13382

8       Plaintiff,               Honorable

9       vs.               Terrence G. Berg

10   CORIZON HEALTH, Inc.,       Magistrate:

11   et al.,               Patricia T. Morris

12

13       Defendants.

14   ----- /

15   Pages 1-102

16

17       The Virtual, Videotaped Deposition of  
18   Jeffrey Bomber, D.O., taken pursuant to Notice in  
19   the above-entitled cause, via Zoom, on May 28, 2021,  
20   at 11:00 a.m., before Carol Marie Hicks, CSR-3345,  
21   Notary Public in and for the County of Livingston.

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25

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19 Prime Healthcare Services and

20 Colleen Spencer.

21

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23

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25

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1 APPEARANCES - (cont'd.)

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12 Keith Papendick, M.D.

13

14 ALSO PRESENT: STEVE ALFONSI, VIDEOGRAPHER

15

16 (All parties appeared via Zoom.)

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12 Michigan

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4 Orlebecke, M.D.,

5 November 10, 2014

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7 Squier, M.D.,

8 November 18, 2014

9

10 (Attached.)

11

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1 May 28, 2021

2 At or about 11:00 a.m.

3 JEFFREY BOMBER, D.O.,

4 having first been duly sworn, was examined and testified

5 on his oath as follows:

6 THE VIDEOGRAPHER: We're now on the

7 record. This is the video-recorded deposition of

8 Dr. Jeffrey Bomber, being taken virtually. Today is

9 May 28, 2021, and the time is 11 a.m. Would the

10 attorneys please identify themselves and the court

11 reporter please swear in the witness.

12 MR. CROSS: Good morning. Ian Cross

13 on behalf of the plaintiff Kohchise Jackson.

14 MR. WILLIS: Good morning. Kenneth

15 Willis on behalf of defendant Prime Healthcare

16 Services and Colleen Spencer.

17 MR. SCARBER: Good morning. Devlin

18 Scarber appearing on behalf of the Corizon

19 defendants in this case, Corizon and Dr. Papendick.

20 JEFFREY BOMBER, D.O.,

21 having first been duly sworn, was examined and testified

22 on his oath as follows:

23 EXAMINATION

24 BY MR. CROSS:

25 Q Good morning, Dr. Bomber. Have you ever had your

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1 deposition taken before?

2 A Yes, I have.

3 Q So I'm just going to go over some ground rules, even

4 though you probably already know. I need verbal

5 responses, no head nod, head shaking, so that the

6 court reporter can get something on the record.

7 It's not an endurance test. If you need a break, if

8 you need to use the bathroom, just let me know, and

9 we'll take a break. I'd just ask that you answer

10 the last question that I pose before the break,

11 okay?

12 A Yes.

13 Q And if you don't understand any of my questions, I

14 don't want you to guess, I want you to ask me to

15 clarify, all right?

16 A Yes.

17 Q All right. When was the last time you were deposed?

18 A Last time I was deposed; approximately one year ago.

19 Q Do you remember what case it was?

20 A I believe it was -- there were a couple of cases in

21 a row, so I'd have to look back at the record.

22 Q Okay. So, there was one involving a gentleman by

23 the name of Kensu; is that correct?

24 A I appeared in court for a Kensu case, and did one

25 deposition, as well, for a Kensu case.



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1 Q Okay. And there was a Spiller?

2 A Yes, I recall a Spiller.

3 Q And there was an Estate of Franklin?

4 A I recall a Franklin.

5 Q And there was an estate of Warren?

6 A Warren, yes.

7 Q Are there any that I'm missing?

8 A Those are the ones that come to mind right now.

9 Q But it's possible there's another?

10 A It's possible.

11 Q Okay. Can you give me a run down of your employment

12 history since 2009.

13 A In 2009 I served as the site medical provider at the

14 Newberry Correctional Facility, and also worked at

15 Helen Newberry Joy as a staff physician. Subsequent

16 to that, I became the northern regional medical

17 director for PHS, which is now Corizon Health.

18 Q Okay. How long did you do that?

19 A I was a northern regional medical director for six

20 years.

21 Q What were your duties as a northern regional medical

22 director?

23 A My duties were to supervise the medical providers in

24 the region.

25 Q What did you do after you were the northern regional

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1 medical director?

2 A After I was the northern regional medical director I

3 became the state medical director for Corizon

4 Health.

5 Q And when did that -- was that a promotion?

6 A Yes.

7 Q When did you get that promotion?

8 A I served as state medical director for four years,

9 so that would be from 2015 through August of 2019.

10 Q And you are no longer the state medical director?

11 A I am not. I concluded that in August of 2019.

12 Q So what have you done for a living between

13 August 2019 and the present?

14 A I am a staff physician at Schoolcraft Memorial

15 Hospital in Manistique, Michigan, and I'm the

16 medical director for the Naubinway Rural Health

17 Clinic, and I also consult with Corizon Health. I'm

18 a contract employee, still, for Corizon Health.

19 Q So why did you cease to be the state medical

20 director?

21 A I was the medical director for four years, and it

22 required living in Lansing for a significant amount

23 of time, and my main home is in Naubinway, and I was

24 ready to be back home.

25 Q I see. And what are your duties now as a contractor

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1 for Corizon Health?

2 A As a contract employee I help to supervise the  
3 providers at seven sites in the northern region.

4 Q So how is that different from when you were the  
5 northern regional medical director?

6 A Well, I only have seven sites at this time. When I  
7 was the northern director, I had 21 sites.

8 Q Oh, okay. So is there another individual who's now  
9 the northern regional medical director?

10 A The sites have been redistributed.

11 Q Was there ever a time when you worked in utilization  
12 management, perhaps temporarily, due to a vacancy?

13 A Yes, when I was the northern regional medical  
14 director we were without a utilization management  
15 physician for a couple of months and so all of us  
16 pitched in for that time period. The state medical  
17 director at the time was Dr. Orlebeck and I was one  
18 of her regional medical directors and we assisted  
19 with the process.

20 Q Can you describe what you did, what those temporary  
21 duties consisted of.

22 A Yes. So, there's a form, a No. 407, which is an  
23 MDOC form, that a provider completes in order to  
24 request a specialty service of some type, and that  
25 request is reviewed by the utilization management

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1 physician.

2 Q Okay. And what does the utilization management  
3 physician do when reviewing that request?

4 A They review it for medical necessary; and, if  
5 medical necessity is demonstrated, the procedure or  
6 the referral is approved or an alternative treatment  
7 plan is offered.

8 Q All right. In your current position as a  
9 contractor, are you able to hire medical providers?

10 A I am involved in the hiring process, I'm part of the  
11 interview team.

12 Q Were you able to hire medical providers when you  
13 were the regional medical director for the northern  
14 region?

15 A Yes; again, I was part of a team, it was a team  
16 evaluation.

17 Q I see. Do you train the providers?

18 A I trained the providers up until the time I became  
19 state medical director.

20 Q And have you trained new providers since you became  
21 a contractor?

22 A I have not trained them in the formal sense --  
23 formal sense being when we met with them and went  
24 over the training materials -- I don't do that  
25 anymore. I do follow up with them, do phone

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1 meetings and chart reviews in order to make sure  
2 that they're acclimating and doing well.

3 Q Okay. Tell me about the onboarding process for a  
4 new provider; what training materials do they  
5 receive, if any?

6 A So, they -- before COVID -- they would have two days  
7 of training in the Lansing office, in person, with  
8 an RMD and review the Corizon provider training  
9 manual; they would also have training in IT for the  
10 electronic medical record; and there were also  
11 modules required by the Michigan Department of  
12 Corrections.

13 Q So, in the course of the onboarding process, did the  
14 new provider ever watch a video?

15 A I do not recall any videos.

16 Q Are there any quizzes that they have to take?

17 A There was a questionnaire, I believe it was based on  
18 the clinical modules; I think there was a module on  
19 diabetes, prostate cancer, a couple others. So  
20 there were some questions, medical questions.

21 (Bomber Deposition Exhibit No. 2 was  
22 marked for identification.)

23 Q Okay. I'm going to show you an exhibit. We'll call  
24 this Plaintiff's Exhibit 2. Can you see the  
25 document?

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1 A Yes, I can.

2 Q You recognize it?

3 A That looks like, yeah, the "Practitioner Clinical

4 Onboarding Checklist."

5 Q Okay. Did you provide any of the training in this

6 checklist to new providers?

7 A I did provide some of the training, yes.

8 Q Was there another person who provided other portions

9 of the training?

10 A Yes, there are other people.

11 Q Who are they?

12 A The office manager, the IT director, and the

13 regional operations manager.

14 Q And are those Corizon employees?

15 A Yes.

16 Q And regional operations manager is what you said?

17 A Yes. Oh, and some of the siting -- some of the

18 training was done on-site with the MDOC health unit

19 manager.

20 Q Okay. So HUM did some of it.

21 A Correct.

22 Q So this is Corizon's training; is there a separate

23 set of modules that are MDOC training that they also

24 received?

25 A Yes, there are modules. Most of those deal with

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1 safety in the correctional environment.

2 Q So, can you point out which portion of this  
3 onboarding you were responsible for providing the  
4 training for.

5 A Sure. I would review the "Corizon Culture of  
6 Patient Safety" in our patient safety program; I  
7 would review --

8 Q Where is that? Culture of patient, okay.

9 A Yeah, I would review that portion. I would review  
10 some of it in "The Correctional Environment"; of  
11 course, some of that is done with the MDOC and  
12 on-site. We would review the "Behavioral Health"  
13 section; we would review the "Correctional  
14 Healthcare Policies and Procedures," I believe all  
15 of those were reviewed; I would review the  
16 "Documentation and Medical Records"; and the  
17 "Utilization Management portion; and "Pharmacy."

18 Q How about in Phase II --

19 A And that's down on that page.

20 Q -- were you involved in any of these trainings?

21 A The "Correctional Environment" would be done on-site  
22 with the HUM.

23 Q Um-hum.

24 A The "Medical Management Model: Decision Support  
25 System," that would be done by me or the regional

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1 medical director; the pharmacy training, a lot of  
2 that had to do with the IT and how to put in orders  
3 so IT would do part of that and we would do part of  
4 the pharmacy training; the "Quality Improvement  
5 Program," yes, we would do that; and the "Behavioral  
6 Health," we would do that; under "Legal and Risk  
7 Management," I recall some training on forensics and  
8 patient safety reporting; "Correctional Healthcare  
9 Policies and Procedures," we also reviewed, we  
10 reviewed those as well.

11 Q Okay. And this first part, "Accountable Care in the  
12 Patient Centered Medical Home Environment," who was  
13 responsible for this section?

14 A I was responsible for the "Corizon Culture of  
15 Patient Safety." I'm not sure, I would think the  
16 regional managers did the "Accountable Care  
17 Organization" sections. The "Contract Overview,"  
18 the "Full Risk, Shared Risk, Pass Through," I'm not  
19 familiar with what all those mean. So that would be  
20 something that operations and office manager would  
21 train on.

22 Q Who is the regional operations manager?

23 A The head, VP of operations, Mason Gill; and he has  
24 had several people over the last ten years report to  
25 him, generally, there are two; I believe, currently,



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1 it's Sara Goff.

2 Q Sara Goff. So she would be the one to do the first

3 section, like the "Contract Overview, Full Risk

4 Shared Risk, Pass Through"?

5 A Right, that wasn't a medical part. We focused on

6 the medical parts. Anything that deal with

7 operations, they would have to do.

8 Q So, you said you did this "Quality Improvement

9 Program" section?

10 A Yes.

11 Q I want to direct your attention to the second to

12 last bullet point, "Key performance indicators,

13 slash, Process Indicators and Quality Indicators."

14 What is that?

15 A I didn't calculate or have anything to do with those

16 KPIs. We did report quality data to the MDOC, as

17 required in the contract.

18 Q Well, I'm asking you what you trained the new

19 providers about with respect to that issue.

20 A We trained the providers on what quality indicators

21 the Michigan Department of Correction tracked.

22 Q What about key performance indicators? What did you

23 teach them about key performance indicators?

24 A Nothing.

25 Q Nothing?

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1 A Nothing.

2 Q Does Corizon have any key performance indicators,  
3 that you're aware of?

4 MR. SCARBER: I'll just make an  
5 objection to form; broad, overbroad base. But if  
6 the witness can go, go ahead.

7 A I do not have anything to do with key performance  
8 indicators or calculations. I'm familiar with the  
9 term, and I do believe that the corporate office  
10 does have KPIs.

11 BY MR. CROSS:

12 Q So what's a KPI?

13 A As I -- and, again, we don't use the term -- we  
14 don't use the term when discussing the quality  
15 indicators with the Michigan Department of  
16 Corrections. But I believe healthcare organizations  
17 use KPIs to track emergency room runs,  
18 hospitalization days, all-around utilization.

19 Q All-around utilization; what do you mean by that?

20 A So, if I have a patient go to the ER and utilize the  
21 ER, that's a utilization.

22 Q So ER runs would be a KPI?

23 A Again, I don't calculate them. I don't look at the  
24 data. I can't tell I exactly what Corizon's KPIs  
25 are.

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1 Q Okay. I'm going to show you another document.

2 THE COURT REPORTER: And are you

3 marking these as exhibits, Mr. Cross?

4 MR. CROSS: Yes, the previous one was

5 Exhibit 2.

6 (Bomber Deposition Exhibit No. 3 was

7 marked for identification.)

8 BY MR. CROSS:

9 Q I'm sorry, can you see the document?

10 A Yes.

11 Q Have you ever interacted with this Bethany Chester

12 person in a professional capacity?

13 A Yes.

14 Q She work for Corizon?

15 A Yes.

16 Q I want to direct your attention to the second

17 dash -- well, what is this document, first of all?

18 What does it appear to be?

19 A It looks like a job description.

20 MR. SCARBER: Is that a resume? I'm

21 sorry, Ian.

22 MR. CROSS: I think it's a resume.

23 MR. SCARBER: Okay. I mean, I see --

24 A I don't know.

25 MR. SCARBER: He's looking at

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1 segments of it 'cause the way it was being scrolled  
2 down.

3 A Yeah, now I see the name. So, I guess, it looks  
4 like a resume.

5 BY MR. CROSS:

6 Q Okay. I want to go to the second dash in her  
7 "Professional Experience"; it says, "Creating,  
8 maintaining, managing emergency room, inpatient,  
9 hospice and palliative care, utilization management  
10 and COVID-19 data for monthly reporting to state  
11 medical director and Michigan Department of  
12 Corrections." You were the state medical director  
13 after October of 2017; is that correct?

14 A Correct.

15 Q Did you receive monthly reports containing emergency  
16 room, inpatient, hospice and palliative care,  
17 utilization management, et cetera, data from this  
18 Bethany Chester person?

19 A Yes. If you look at the MDOC contract, those  
20 numbers are required, that we are required to report  
21 those numbers to the Michigan Department of  
22 Corrections on a monthly basis.

23 Q And she didn't just report those numbers to the  
24 Michigan Department of Corrections, she also  
25 reported them to you, right?

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1 A Well, to me, but the numbers were shared as part of  
2 the monthly report with the Department.

3 Q So did you -- you received the report, Exhibit 1?

4 A Yes.

5 Q What did you do with that data?

6 A It was given to the MDOC in a monthly report.

7 Q So the only reason it came to you was for to you  
8 give it to the MDOC?

9 A No, several people help write that report, including  
10 myself.

11 Q Okay. So you participate in creating a report for  
12 the MDOC --

13 A Yes.

14 Q -- containing all of this data.

15 A Yes, there's a whole list of the required numbers in  
16 the contract.

17 Q And is the only reason that Corizon tracks that data  
18 to comply with the contractual requirement to report  
19 it to the MDOC?

20 A I can't tell you all the reasons Corizon would track  
21 that data.

22 Q Can you tell me any of the reasons?

23 MR. SCARBUR: I'll just place an  
24 objection; calls for speculation.

25 A My role was to provide the numbers per the

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1 contractual agreement.

2 BY MR. CROSS:

3 Q So you can't tell me any of the reasons?

4 MR. SCARBER: Just going to place

5 another objection; asked and answered.

6 A I can't tell you the reasons Corizon would want to

7 see the data. I can tell you that I needed to see

8 the data because it was required that I report that

9 to the Michigan Department of Corrections.

10 BY MR. CROSS:

11 Q Okay. So, does Corizon track any performance

12 measures or indicators for the MDOC contract?

13 MR. SCARBER: Just going to place an

14 objection; that seems like that was asked and

15 answered and it's been discussed over the last

16 several minutes of your questions. But to the

17 extent it's a different question or you have a

18 different answer.

19 A I do not have a different answer. My requirement

20 was to provide the data to the Department of

21 Corrections.

22 BY MR. CROSS:

23 Q I'm not asking if you provided data to the

24 Department of Corrections. I'm asking if Corizon

25 tracks any performance measures or indicators for

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1 the MDOC contract, to your knowledge?

2 MR. SCARBER: Objection; asked and  
3 answered.

4 A I believe that they looked at the monthly reports  
5 that we provided to the DOC; beyond that, I don't  
6 know.

7 BY MR. CROSS:

8 Q All right. I'm going to show you another document.  
9 We'll mark this Plaintiff's Exhibit 4.

10 (Bomber Deposition Exhibit No. 4 was  
11 marked for identification.)

12 Q Have you ever used a computer program that looks  
13 like that, sir?

14 A I have not used it. I know that Corizon has  
15 something called InGauge that they used to use for  
16 their utilization management. We didn't use the  
17 data.

18 Q So, who uses InGauge?

19 A I believe corporate, it's used at the corporate  
20 level.

21 Q So that would be, what, C Suite executives?

22 MR. SCARBER: I'm going to place an  
23 objection; calls for speculation; if you know, any  
24 more than you said.

25 A I know Corizon leadership looks at InGauge.

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1 BY MR. CROSS:

2 Q So you've never used this.

3 A I've not used their data, no. We generated our data  
4 for the DOC from the electronic medical record, as  
5 well as the inpatient team and the on-site  
6 utilization management clerks and RNs.

7 Q Do you know if this program is still in use?

8 A I, frankly, don't. Like I said, I don't use it.

9 Q Okay. If I wanted to talk to someone who uses it,  
10 who would that be?

11 A That would be somebody at the corporate level for  
12 Corizon.

13 Q What's the corporate level? What does that mean?

14 A That would mean those at the Corizon headquarters  
15 Nashville, Tennessee.

16 Q Okay. So no one in Michigan uses this.

17 A We don't use it.

18 Q What is utilization management?

19 A Utilization management is monitoring the amount of  
20 utilization in a medical contract.

21 Q What's the purpose of utilization management?

22 A From my point of view, providing numbers to the  
23 Michigan Department of Corrections, as contractually  
24 obligated to; also, to monitor, like, if there's  
25 been an intervention. For example, when we started



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1 to utilize the Impact Pro, we wanted to ensure that  
2 quality measures were being met and that inmates  
3 were -- we were ensuring that inmates were getting  
4 their medical needs met. So we would monitor the  
5 number of referrals, for example, to make sure that  
6 they were getting adequate care.

7 Q So the purpose of utilization management is to  
8 report data to the MDOC?

9 A No, and also monitor the quality of care.

10 Q Monitor the quality of care. So, when you were  
11 acting as a utilization review physician, in a  
12 temporary capacity, you were monitoring the quality  
13 of care?

14 A As a utilization management physician, I was  
15 monitoring the off-site referral request, ensuring  
16 medical necessity, and approving or giving an ATP.

17 Q I see. Does the utilization management physician  
18 reviewer consider costs when making his or her  
19 decisions?

20 A No, cost is never an issue in anything we do as  
21 medical providers.

22 Q So utilization management never considers cost.

23 A Not from my perspective; in fact, we're instructed  
24 by operations to practice medicine based on medical  
25 necessity, not cost.

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1 Q Not cost. Okay. Well, that's -- let me show you  
2 another document. Hold on, this is -- got this  
3 clock in the way so I can't click on it. Here we  
4 go. Can you see the document, sir?

5 A Yes.

6 Q All right. For the record, this is a 30(b)(6)  
7 deposition you gave in Estate of Franklin. And I  
8 would like you to read out loud, for the record,  
9 lines 10 through 12 on this page.

10 MR. SCARBER: Let me have an  
11 opportunity to review the document, counsel. What  
12 lines do you want him to review?

13 MR. CROSS: 10 through 12.

14 MR. SCARBER: Okay.

15 MR. CROSS: We'll call this  
16 exhibit -- what are we on, 6?

17 MR. SCARBER: I thought the last one  
18 you said was 3.

19 MR. CROSS: All right, 4, then.

20 MR. SCARBER: I don't know. You  
21 better ask Carol.

22 THE COURT REPORTER: I don't know  
23 because I'm not marking them, I don't know.

24 MR. SCARBER: Okay. Maybe ken got  
25 another one, I was right and you could have said

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1 another one, I'm not sure. Hang on.

2 MR. WILLIS: I only heard 3 or for

3 the last one, I think, but I could be wrong.

4 BY MR. CROSS:

5 Q This InGauge screenshot, we'll call this Exhibit 4,

6 and then I haven't shown you another one since this,

7 before the deposition transcript, so we'll call the

8 deposition transcript -- you know, we'll call it 7,

9 'cause I've already saved a couple as 5 and 6.

10 So could you read lines 10 through 12

11 of this transcript for the record?

12 A Sure.

13 "And that the utilization management

14 component of the review process takes into

15 consideration cost, correct"?

16 "Yes."

17 Did you say line 13, too?

18 Q Nope.

19 A Okay.

20 Q So it sounds like your testimony, in this case, was

21 that the utilization management component of the

22 review process -- well, this review process, I want

23 you to look at lines 3 through 8, so we know what

24 review process we're talking about here.

25 MR. SCARBER: Well, hang on, I'm

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1 going to object to form, 'cause it sounds like you  
2 were asking him a question and now you're asking him  
3 to review something again.

4 MR. CROSS: Okay.

5 MR. SCARBER: So what do you want him  
6 to look at now?

7 MR. CROSS: Lines 3 through 8, or 3  
8 through 9.

9 MR. SCARBER: Okay. Hang on. Take a  
10 look at that. Okay. Go ahead.

11 BY MR. CROSS:

12 Q Okay. So would it be fair to say that your  
13 testimony, in this case, was that the utilization  
14 management component of the 407 review process takes  
15 into consideration cost?

16 MR. SCARBER: I'm going to place an  
17 objection that it looks like it's taken out of  
18 context, so I object to form and mischaracterization  
19 of the document. But go ahead.

20 A So the context is as a provider, as a utilization  
21 management reviewer, as a state medical director, I  
22 do not consider costs, it's always medical  
23 necessity.

24 Yes, I'm sure that at the -- probably  
25 the DOC and at the corporate level they do review

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1 costs. But, yes, they do consider costs. On a  
2 daily basis, I don't think about cost.

3 Q So what were you talking about here in this  
4 testimony when you said it "takes into consideration  
5 costs"? "Yes."

6 MR. SCARBER: Let me place another  
7 objection. I mean, to give him two lines out of a,  
8 it looks like this is page 232 of a deposition, and  
9 ask him what he was talking about, I think, is an  
10 unfair question. So I object that the -- I'll  
11 object to form and taking the document out of  
12 context.

13 MR. CROSS: I'll object to your  
14 speaking objection.

15 MR. SCARBER: Can you tell him what  
16 you were talking about in just one page of a  
17 200-page deposition?

18 THE WITNESS: I'm speculating.

19 MR. SCARBER: Okay.

20 MR. CROSS: Devlin, you're coaching  
21 the witness.

22 MR. SCARBER: You just asked the  
23 witness, with all due respect, counsel, to tell him  
24 what he was talking about after reading 12 lines of  
25 a deposition.

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1 MR. CROSS: If you'd like to read

2 more of it, he can.

3 MR. SCARBER: He's not going to sit

4 here and read -- the question has to be a question

5 he can answer without reading 100 pages or 200 pages

6 of a deposition. I mean, if you want to put it in

7 some kind of context, that's fine. But my objection

8 is to form, and I'm not trying to coach the witness

9 on this, but I think it's -- I think it's an unfair

10 question that requires a very detailed objection.

11 (Bomber Deposition Exhibit No. 5 was

12 marked for identification.)

13 BY MR. CROSS:

14 Q Okay. Let's move on. I'm going to show you what's

15 been marked Plaintiff's Exhibit 5. Have you ever

16 interacted with this Lori Mignon Ernst individual in

17 a professional capacity?

18 A Yes.

19 Q Okay. You know who she is?

20 A Yes.

21 Q And what is this document, for the record?

22 A It looks like another resume.

23 Q Okay. I want to direct your attention to the one,

24 two, three, four, fifth dash here, under "Director

25 of Utilization Management: Set up UM processes

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1 within each region with CCO/COO to ensure maximum  
2 effectiveness" -- oh, I'm sorry, the next one --  
3 strike that. "Work with CCO/RMD within regions to  
4 identify barriers and to find solutions for problems  
5 and align the contract in meeting with UM targets."

6 A Yes, I see it.

7 Q Did Ms. Ernst ever work with you to align the  
8 Michigan contract in meeting with UM targets?

9 A No.

10 Q Is it fair to say that UM stands for utilization  
11 management?

12 A Yes.

13 Q Okay. Did anyone work with you to align the  
14 Michigan contract in meeting with utilization  
15 management targets?

16 A I'm not even sure how targets is defined.

17 Q Well, how would you define it?

18 A I have no idea how they define it, it's not given  
19 here.

20 MR. SCARBER: And let me just place  
21 an objection as to foundation. This isn't his  
22 resume, he didn't draft this, he has no idea what  
23 this stuff means.

24 BY MR. CROSS:

25 Q So you testified that you have interacted with

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1 Ms. Ernst in a professional capacity, correct?

2 A Correct.

3 Q And between 2013 and 2015, you were the regional

4 medical director, that was your title, correct?

5 A Yes.

6 Q So, if Ms. Ernst is saying that she worked with RMD,

7 does RMD stand for regional medical director?

8 A Yes.

9 Q So what did you -- strike that. When you worked

10 with Ms. Ernst, what did you do?

11 A So, my main interaction with Ms. Ernst was when we

12 went to a centralized model for utilization

13 management, our portion, our participation for

14 Michigan.

15 Q Are there utilization management targets for the

16 Michigan contract?

17 A No.

18 Q Were there ever utilization management targets for

19 the Michigan contract?

20 A Not for me, sir, never.

21 Q Not for you, sir? What do you mean by that?

22 A Not for the medical providers, not for the regional

23 medical directors, we were never given targets.

24 Q So who are the targets for?

25 A I don't even know how they're defined. I would just



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1 be guessing.

2 Q All right. The next one in this resume, "Daily  
3 review of Pipes/QNXT"; do you know what that is?

4 A I do not.

5 Q "Reports including inpatient tracking and outpatient  
6 referrals of all contacts to monitor and ensure  
7 compliance with targeted budget."

8 Is there a targeted budget for the  
9 MDOC contracts for Corizon?

10 A I'm not sure what targeted budget is. We did have a  
11 budget from the DOC contract. I have no idea what a  
12 targeted budget is.

13 Q How is the budget set?

14 A Well, there were a certain number of dollars over a  
15 five-year period that were allotted for medical  
16 management.

17 Q By Corizon.

18 A No, actually, by the DOC; that was in the DOC  
19 contract.

20 Q So there's a contract with the DOC that states how  
21 much the DOC is paying Corizon for medical  
22 management, correct --

23 A Yes.

24 Q -- more or less? And then does Corizon internally  
25 have a budget for how much it wants to spend on

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1 medical management in Michigan?

2 A I would -- I think. I don't know.

3 Q You don't know anything about that.

4 A I don't have anything to do with preparing those

5 budgets, if they exist.

6 Q And you don't know how reviewing inpatient tracking

7 and outpatient referrals could help ensure

8 compliance with the targeted budget?

9 A I would be speculating. I have no part in that.

10 Q Okay. So you testified that your interactions with

11 Ms. Ernst were primarily related to a move to

12 centralize utilization management?

13 A Yes.

14 (Bomber Deposition Exhibit No. 6 was

15 marked for identification.)

16 Q All right. Let's look at what we will call

17 Plaintiff's Exhibit 6. And this resume was 5, in

18 case I forgot to note it. And this is Bates 103,

19 the "Utilization Management Manual," produced by

20 Corizon. So, see here it says the "Utilization

21 Management Core Process will launch in January of

22 2017"?

23 A Yes, I see that.

24 Q What is the Utilization Management Core Process?

25 A I believe that was when we went to the centralized

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1 UM process.

2 Q And how is that different from the previous  
3 practice?

4 A In the previous practice, there was just one  
5 utilization management physician. But in the new  
6 practice now, Dr. Papendick, who's currently the  
7 UMMD for the Michigan contract, is now supported by  
8 two other utilization management physicians; he has  
9 back up and support, you know, if he needs vacation  
10 or whatever. So those physicians are now all  
11 Corizon employees.

12 Q So Dr. Papendick is a Corizon employee?

13 A I don't know what -- if he's Quality Correction or  
14 Corizon now. I haven't been the state medical  
15 director for going on two years, so I'm not sure  
16 what his current designation is.

17 Q When you were the state medical director, were you a  
18 Corizon employee?

19 A No, I was employed by Quality Correctional Care of  
20 Michigan.

21 Q What is Quality Correctional Care of Michigan?

22 A Quality Correctional Care of Michigan is a  
23 professional corporation, a PC.

24 Q In, say, 2017, who was the president of Quality  
25 Correctional Care of Michigan?

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1 A I was.

2 Q And this is a corporation, correct?

3 A A professional corporation.

4 Q Who were the shareholders of Quality Correctional

5 Care of Michigan, PC?

6 A I believe there was myself and Dr. Sylvia McQueen.

7 Q Dr. Sylvia McQueen; is she licensed to practice

8 medicine in Michigan?

9 A I don't know.

10 (Bomber Deposition Exhibit No. 1 was

11 marked for identification.)

12 Q All right. I'm going to show you what's been marked

13 Plaintiff's Exhibit 1; and this is from the LARA

14 Corporations Online Filing System; and it says the

15 names and addresses of all shareholders, and we just

16 have one shareholder here, and that would be you,

17 correct?

18 A It looks like it.

19 Q So you were the sole shareholder of this

20 corporation.

21 MR. SCARBER: I'm just going to place

22 an objection only to a time -- a point in time, like

23 when is it dated or when is this from?

24 MR. CROSS: This was filed in 2018.

25 MR. SCARBER: Okay.

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1 BY MR. CROSS:

2 Q So, did Quality Correctional -- what is this --

3 Quality Correctional Care of Michigan, PC, make a  
4 profit in that year?

5 A No, there's no profit, none.

6 Q Did it lose money?

7 A You'd have to ask the operations director because I  
8 believe there may have been a loss year. But that  
9 would be information you'd have to obtain from  
10 operations. It was, essentially, a nonprofit.

11 Q It was a nonprofit.

12 A Essentially, it was a way -- in Michigan you can  
13 only practice medicine under, I think it's four  
14 different entities, and a PC is one of them. So  
15 Corizon would contract with Quality Correctional  
16 Care to provide the medical care to provide the  
17 providers.

18 Q Did Quality Correctional Care of Michigan have any  
19 other clients other than Corizon?

20 A No.

21 Q Does Quality Correctional Care of Michigan have any  
22 plans for mass layoffs in the near future?

23 MR. SCARBER: Let me just place an  
24 objection to relevance, and, you know, asking about  
25 the business decisions, which are probably

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1 proprietary or confidential concerning a defendant  
2 that's not even in the case or party that's not even  
3 in the case. But go ahead, if you can answer.

4 A I'm not a part of the leadership with Quality  
5 Correctional Care, so I don't know.

6 BY MR. CROSS:

7 Q Okay. Is it fair to say that Quality Correctional  
8 Care passes through its expenses to Corizon?

9 A Yes.

10 Q Okay. So let's go back to what we were talking  
11 about before. This is Exhibit 6, the "Utilization  
12 Management Core Process."

13 I want to direct your attention to  
14 this section about how the success of the program  
15 will be measured. It says, "We will focus  
16 specifically on outpatient referrals per thousand,  
17 claims per thousand, referrals per UMMD, claims  
18 without a referral, ATPs and percent ATPs  
19 overturned."

20 What's the difference between  
21 outpatient referrals per thousand and claims per  
22 thousand?

23 A I'm not sure. It's nothing that we tracked or  
24 presented. I would speculate that the outpatient  
25 referrals are the pure number of patients referred;

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1 and, claims, that would, to me, infer that there was  
2 some sort of cost claim made or charge associated  
3 with that.

4 Q Like a dollar amount.

5 A Yeah, like if you go to the emergency room there's,  
6 you know, a cost associated with that; or if you see  
7 a specialist, there's an office fee; if they do a  
8 surgery, there'd be a surgery fee. That's generally  
9 what I understand to be a claim. So that specialist  
10 would file a claim or a charge.

11 Q All right. And see this, like, first clear, or not  
12 filled-in, bullet point here that says, "30/60/90  
13 day review RMDs and UMMDs"?

14 A I see it.

15 Q Were you involved in those 30-, 60- or 90-day  
16 reviews of the success of this program?

17 A No.

18 Q Okay. Do you know how a metric like outpatient  
19 referrals per thousand would indicate success versus  
20 failure of this program?

21 A I wasn't part of the development of that program nor  
22 was I part of the ongoing meetings with that  
23 program; it wasn't part of my job description, my  
24 duties.

25 Q Okay. So, let's go to this section about how RMDs

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1 will monitor and remain knowledgeable of referral

2 and ATP activity. "RMDs will review: Detailed

3 daily reports of all ATPs." Did you do that?

4 A Yeah, as you can see in the monthly report to the

5 DOC, we did report the percentage of ATPs.

6 Q And was the only reason you did that to report it to

7 the DOC?

8 A Well, I certainly wouldn't want the number of ATPs

9 to start going up. So I would look at it to make

10 sure that we were, you know, at or around our

11 average, because we want to make sure that the

12 inmates are getting the care that they need. So we

13 would look at it from a quality point of view.

14 Q So is there a goal or target for the percentage of

15 ATPs that are -- I mean -- or, I'm sorry, the

16 percentage of requests that are approved versus

17 ATP'd?

18 A There's no goal or requirement, that I'm aware of.

19 We did track it to make sure that, if there was a

20 trend, we'd want to explain why.

21 Q Okay. Is that something you track at the individual

22 provider level?

23 A We would look at that in the beginning with a new

24 provider. Often, when you first get into the system

25 and you're learning how to use Uptodate and learning



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1 the referral system, a new provider might have a  
2 higher number of ATPs, and so we would help them be  
3 able to write more detailed and more medically  
4 necessary type referrals.

5 As far as tracking it provider by  
6 provider, there were times where we did that. It  
7 wasn't anything that we did regularly.

8 Q So when would you do that?

9 A There were a couple of times where the Michigan  
10 Department of Corrections requested that, so we did  
11 provide that data.

12 Q I'm going to take you down a page, this is still the  
13 same exhibit. This chart here, does that accurately  
14 represent the workflow of the Utilization Management  
15 Core Process, as you understand it?

16 A It's very small and I would need a few minutes to  
17 look at it.

18 Q All right.

19 A Actually, I have to take my glasses off to do -- oh,  
20 we have a copy right here. Okay. Yeah, this looks  
21 to be the process that's being used now.

22 Q Okay. Let's go through it. So it starts with the  
23 outpatient referral request; that's done by a  
24 medical provider at the site, correct?

25 A Yes.

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1 Q And if that request is missing information or it's  
2 not detailed enough, there's this UM nurse review,  
3 and it looks like there's an arrow that goes back to  
4 the provider. So would the UM nurse determine if  
5 there wasn't enough information in the request and  
6 then ask the provider to resubmit it, if that the  
7 case?

8 A Not resubmit. If there was a missing section, a  
9 blank part of the form, the provider would give that  
10 information to the UM nurse and they would complete  
11 the same 407. So they wouldn't have to file a new  
12 one.

13 Q Okay. So the UM nurse makes sure that the request  
14 is complete.

15 A Correct.

16 Q And it has all the information that the physician  
17 reviewer would need to make a decision.

18 A From a clerical point of view, not a medical  
19 decision-making point of view.

20 Q Okay. But she's not making the medical decision,  
21 but she's making sure that there's enough  
22 information for a physician to make a medical  
23 decision.

24 A Correct.

25 Q Okay. So then the next box we have is called pass

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1 through list. What's that?

2 A That would be like a pacemaker check; automatic  
3 approvals.

4 Q All right. So there's a list of things that are  
5 automatically approved.

6 A Correct.

7 Q And if it's on the pass through list, then we get a  
8 yes, and we go directly to referral authorized,  
9 right?

10 A Correct.

11 Q And does the physician reviewer determine if the  
12 procedure is on the pass through list?

13 A That list was developed by physicians.

14 Q Okay. But the person who compares the request to  
15 the list, is that a physician?

16 A No, they review the pass through list, and, if it's  
17 appropriate for that, it's automatically given an  
18 authorization.

19 Q Okay. And that's the nurse reviewer who does that?

20 A Correct.

21 Q Okay. Now, if it's not on the pass through list,  
22 then it goes to the utilization management medical  
23 director, right?

24 A Yes.

25 Q And it goes to him via, what, an email?

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1 A Yes, it's -- well, now it's all electronic now.

2 Q Okay.

3 A Yes.

4 Q If I say the word "407 group," do you know what that  
5 is?

6 A That's the email group that the 407 request is sent  
7 out to.

8 Q And who's in the email group?

9 A That would be the provider, the UMMD nurse and  
10 provider, and then whoever on-site helps to manage  
11 the 407 process, usually the HUM, as well as the  
12 health information manager.

13 Q And are those sent to the Michigan.gov emails for  
14 these individuals or are they sent to Corizon health  
15 emails?

16 A That would all be through the EMR now. So, back  
17 then, it would be through the DOC email process.

18 Q So the email is within the EMR?

19 A Yeah, now there are messages within the EMR  
20 regarding the 407s. I believe they still have the  
21 email groups, though, too.

22 Q So if I were to order a prisoner's medical records,  
23 they would include those messages or would they not?

24 MR. SCARBER: Just going to place an  
25 objection to foundation, as to whether he would know

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1 that. But go ahead.

2 A I'm not sure.

3 MR. SCARBER: And my objection, Ian,  
4 is, more or less, he doesn't know what the MDOC  
5 would give you or be able to produce for you because  
6 I think your question asked 'if you ordered records,  
7 what would you get'?

8 MR. CROSS: Okay.

9 MR. SCARBER: That's the basis of my  
10 objection.

11 A I don't know.

12 BY MR. CROSS:

13 Q And you believe it would be the Michigan.gov emails  
14 for those people would receive --

15 A Yes.

16 Q -- those messages? Okay. So, where were we? On  
17 UMMD review. Now, if the UMMD approves the request,  
18 it goes to the UM nurse, who adds detail attributes.  
19 What does that mean?

20 A Well, there has to be an authorization number  
21 attached now to the 407 so that whoever the  
22 specialist or whatever the provider is has an  
23 authorization number.

24 Q So the UM nurse adds an authorization number and  
25 then the referral is authorized?

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1 A Correct.

2 Q So once the UMMD approves, there's no one else who  
3 has to approve the referral, it's done?

4 A Correct.

5 Q All right. Now, if the UMMD does not approve, are  
6 they required to issue an alternative treatment  
7 plan?

8 A Yes.

9 Q The UMMD cannot deny without issuing an alternative  
10 treatment plan, correct?

11 A There is no such thing as deny.

12 Q Okay.

13 A It's either approved or given an alternative  
14 treatment plan.

15 Q And is the alternative treatment plan typically  
16 something that can be done on-site at the prison?

17 A Not always. It could be that the UMMD physician  
18 thought that an ultrasound may be more appropriate  
19 than a CT scan. So it may be an alteration in the  
20 request or given an ATP, such as self -- a home  
21 exercise program, which can be done on-site. So it  
22 could be either.

23 Q Could be either. Does the UMMD physician have  
24 access to any information that the site physicians  
25 don't have access to, in terms of what is medically

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1 indicated for a given problem?

2 A Site providers have access to whatever they need;

3 they're provided a subscription to Uptodate;

4 They're -- I don't know if it's the same. I can

5 tell you that they both have adequate resources.

6 Q So the site provider has Uptodate and the UMMD also

7 have Uptodate.

8 A Correct.

9 Q And the UMMD uses Uptodate to make his

10 determinations?

11 MR. SCARBER: I'm just going to place

12 an objection to foundation. Are you asking what he

13 does or what somebody else might do or what they're

14 supposed to do? I guess that's my question; form.

15 BY MR. CROSS:

16 Q Okay. So what did you do when you were doing this?

17 A As a site provider?

18 Q No, as a UMMD, as a reviewer.

19 A Oh, for the two months when I did that? Yes, I

20 would utilize Uptodate, at the time, was my main

21 resource; also, the National Cancer website

22 information, sometimes. Mostly Uptodate.

23 Q Okay. So if you -- if an alternative treatment plan

24 is issued, then the ATP goes to the site provider

25 for review, correct?

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1 A Correct.

2 Q And the site provider has two options: They can  
3 either accept the ATP or they cannot accept the ATP.

4 A That's correct.

5 Q And this not accepting the ATP, that's referred to  
6 as an appeal?

7 A Yes, then they have the right to appeal.

8 Q How common are appeals?

9 A I can't quantify it for you. Generally, I  
10 understand, currently, there are one or two a week.

11 Q Has that volume changed at all in your time with  
12 Corizon?

13 A No, it seems to be somewhat steady.

14 Q Okay. Do you know about how many alternative  
15 treatment plans there are a week?

16 A I do not know that, no.

17 Q So, if the site provider does not accept the ATP,  
18 then it goes to the regional medical director,  
19 which, at one point, was you, correct?

20 A Correct.

21 Q And do these appeals go to you now in your current  
22 role?

23 A Yes.

24 Q All right. And are you able to unilaterally  
25 overturn the ATP?



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1 A No, not as a regional director.

2 Q Not as a regional director. So you have two

3 options: You can uphold the ATP, right?

4 A Correct.

5 Q And then you would discuss that with the site

6 provider, and that would be the end of the process.

7 A No.

8 Q No? I mean -- so here I see the arrow goes to

9 uphold ATP, nurse acknowledges, site provider

10 accepts ATP.

11 A No, that is not our process in Michigan.

12 Q So beside upholding, you have another option, you

13 can appeal the ATP, right?

14 A Correct.

15 Q So it comes to you, you can't say, 'I overturn,' but

16 you can uphold or you can appeal again to the CMO.

17 Who's the CMO?

18 A So this doesn't delineate the entire process in

19 Michigan. But the pathway that you just asked me a

20 question on: If the provider comes to me and

21 appeals it, then I send that appeal to the CMO or

22 SMD, state medical director, RMD, council, which

23 meets three times a week, and we discuss the appeal.

24 Q So the appeals -- you're saying, in Michigan,

25 appeals don't go to the Corizon CMO.

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1 A No, no, not -- no. Go ahead.

2 Q This is not an accurate description of the process.

3 A No, no. There are some components not included in  
4 this document.

5 Q All right. So the RMD gets it; the RMD appeals it  
6 to the state medical director; you used to be the  
7 state medical director; then what happens?

8 A It's the state medical director -- there's a council  
9 that meets, it includes the state medical director,  
10 the regional medical director, and they then decide  
11 whether or not to overturn the ATP or uphold the  
12 ATP.

13 Q So that's kind of like this appeals committee review  
14 up here.

15 A I have to look closer. No, it's not exactly like  
16 that, because ultimately the chief medical officer  
17 of the state of Michigan has the ultimate authority.  
18 So, can I walk you through the actual process?

19 Q Yeah, yeah, go ahead.

20 A Okay. So, we're at the appeal level. So the RMD  
21 appeals to the state medical director RMD council;  
22 and if they uphold the ATP, the provider still has  
23 another option and that is to appeal to the chief  
24 medical officer of the state of Michigan that has  
25 ultimate authority, they can do that there; and

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1 then, also, if I uphold the ATP, the provider always  
2 has the option to go to the chief medical officer  
3 for the state of Michigan. There's several levels  
4 of appeal.

5 MR. SCARBER: When you say "state of  
6 Michigan," are you talking about, what, what --  
7 Corizon or another entity?

8 MR. CROSS: I'm asking the questions  
9 here.

10 MR. SCARBER: I understand, but I  
11 need to be clear.

12 THE WITNESS: So it's just between  
13 Corizon and DOC. At this point, there's no one from  
14 Corizon corporate involved in the process.

15 BY MR. CROSS:

16 Q All right. Can the prisoner initiate the appeal  
17 process?

18 A They have a system of grievances.

19 Q I understand they can file a grievance, and that's  
20 handled by the MDOC, right?

21 A Correct.

22 Q But can they initiate the Corizon appeal process  
23 that you just described?

24 A No, I don't believe so.

25 Q Okay. Does Corizon review the performance of

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1 site-level medical providers?

2 A There's an annual review process, yes.

3 Q Have you ever done any kind of performance review of

4 a provider as an RMD or state medical director?

5 A Yes.

6 (Bomber Deposition Exhibit No. 8 was

7 marked for identification.)

8 Q All right. I'm going to show you what we will call

9 Exhibit 8. Do you recognize this document? I mean

10 not what's filled out in it, but just the form

11 itself?

12 A It's not -- it looks like a document that's similar

13 to what we review. We used to review providers in

14 Michigan, but it's not exactly the same, this is a

15 little different.

16 Q How is it different?

17 A Well, the form is a little different, the

18 organization is different; some of the questions are

19 similar, though.

20 Q Okay. Tell me how the form is different; what are

21 the differences, what are the different questions?

22 A Well, I'd have to have the other form in front of

23 me. It's just the way it's organized, the lines,

24 the boxes, they're all a little different.

25 Q Interesting. And you know who this person Keith

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1 Papendick is, right?

2 A Yes.

3 Q And what's his job?

4 A He is a utilization management physician.

5 Q And do you know who this person, James Powell, is?

6 A That would be Dr. Powell, who used to be the chief  
7 medical officer of Corizon.

8 Q Okay. So I'm noticing on this form -- like, let me  
9 direct your attention to No. 5, "Demonstrates  
10 compassion in patient encounters, NA"; that would  
11 stand for not applicable, right? Is that a fair  
12 assumption?

13 A That question, seems to me, would be directed  
14 towards someone who's seeing patients eye to eye,  
15 face to face.

16 Q Exactly. And does Dr. Papendick, in his current  
17 role, see patients eye to eye, face to face?

18 A No.

19 Q So, this form probably isn't specific to utilization  
20 management medical directors, is it?

21 MR. SCARBUR: Just going to place an  
22 objection to speculation and foundation. But go  
23 ahead.

24 A I can't answer that question 'cause I didn't develop  
25 this form nor do I use this exact form.

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1 BY MR. CROSS:

2 Q Okay. Do you have access to the form that you do  
3 use?

4 A Not immediately, no.

5 Q So, I want to direct your attention to the Medical/  
6 Clinical Judgment Section." On the form that you  
7 use, is there something similar to No. 3,  
8 "Prescribes pharmaceutical therapy within the  
9 guidelines of Corizon Health or contracted  
10 formulary"?

11 A There is a question around pharmacy and  
12 pharmaceutical use. Can't tell you exactly if it  
13 reads the same, there is a question.

14 Q There's a question like that?

15 A Yes.

16 Q And what would be the answer that would reflect  
17 better on the site provider, yes or no?

18 A Yes.

19 Q Yes. What's a formulary?

20 A A formulary is a list of medications provided by any  
21 healthcare organization. The MDOC has a formulary  
22 and we're -- that's preferred that we use a drug on  
23 the formulary. It's not the only drugs we can use,  
24 but those are the preferred medications.

25 Q What's the purpose of having a drug formulary?

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1 A A drug, what, I'm sorry?

2 Q What is the purpose of having a drug formulary?

3 A Purpose of having a drug formulary is to make sure  
4 that you provide medications in every category  
5 needed for the patients.

6 Q Well, wouldn't you be able to provide medications in  
7 every category needed for the patients without a  
8 drug formulary?

9 MR. SCARBER: Just going to place an  
10 objection to relevance. Go ahead.

11 A I know there are other reasons for having a  
12 formulary; health entities, hospitals, for example,  
13 clinics, are provided better cost in volume buying  
14 participating in a formulary.

15 BY MR. CROSS:

16 Q So is part of the reason that a health care  
17 organization would use a drug formulary to control  
18 costs?

19 MR. SCARBER: Place an objection as  
20 speculation and mischaracterizes his testimony. But  
21 go ahead.

22 A They use it to provide better pricing and help with  
23 cost, yes.

24 BY MR. CROSS:

25 Q Okay. And so below this question you have a --

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1 strike that. See where it says, "Percentage of  
2 non-formulary medication on-site"?

3 A Yeah, I can tell you we don't track that for the  
4 providers.

5 Q You don't?

6 A No.

7 Q All right. Do you track the number of UM requests  
8 during the last year for the providers?

9 A We do not, and there's a question on that, we just  
10 don't have the data available. So, no, we don't  
11 discuss that in our reviews.

12 Q Do you track the percentage of requests that are  
13 approved?

14 A We track the overall -- now we track the overall  
15 percent of ATPs, yes.

16 Q But do you track the percentage of an individual  
17 providers' 407 requests that are approved?

18 A Previously, I was asked that question, and I did  
19 answer that question before, and, yes,  
20 intermittently that number has been tracked and  
21 provided to the DOC.

22 Q Do you use that number at all in evaluating the  
23 performance of the individual provider?

24 A I don't, no.

25 Q Did Corizon ever use that number in evaluating the



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1 performance of the individual provider?

2 A Not actively.

3 Q What do you mean by "not actively"?

4 A That number may have been provided intermittently to

5 us and the providers. But it was not a part of

6 their annual assessment, it wasn't a factor in

7 evaluating them.

8 Q If a provider has something like a 50 percent ATP

9 approval rate, would they receive any kind of

10 coaching or performance improvement plan?

11 A Intermittently, like I said earlier, typically that

12 would be a new provider who just needs some coaching

13 to help learn the system better. Most of our

14 providers are overall seasoned. We have many

15 providers that have been with us for many years, and

16 they don't have many ATPs.

17 Q They don't have many ATPs at all or they don't have

18 many ATPs as a percentage of their requests?

19 A There are some providers who have virtually hundred

20 percent of their 407s approved, and, you know,

21 others 90, 85 percent. Occasionally, like I say, we

22 get somebody who has a lower approval rate and we

23 want to make sure that they have the tools required

24 to be successful.

25 Q So if someone has a -- if a provider has a lower

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1 approval rate, what changes do they need to make to  
2 be more successful?

3 A Generally, their 407s don't include enough  
4 information or they haven't demonstrated medical  
5 necessity.

6 Q So if it doesn't include enough information -- we  
7 were talking before about this nurse reviewer --  
8 hold on -- this nurse review portion of the  
9 "Utilization Management Core Process Workflow" --

10 A Right.

11 Q -- where the nurse should help them correct that  
12 before it even gets to the physician reviewer,  
13 right?

14 A Usually, yes.

15 Q So if they're not including enough information,  
16 shouldn't that not really affect their ATP  
17 percentage because it gets fixed before it gets to  
18 the doctor?

19 A Yeah, we've improved that part. So, you're correct,  
20 that would be a very, very small percentage of them  
21 now.

22 Q Okay. So, usually, if their percentage is -- their  
23 approval rate is low, it's because they're  
24 requesting things that aren't medically necessary?

25 A Yes.

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1 Q So how does Corizon define medically necessary?

2 A Well, the MDOC has policies, and we also use

3 Uptodate, sometimes available other medical

4 literature, whatever is required.

5 Q So you're telling me that there are some MDOC

6 policies that indicate what's medically necessary

7 and what's not medically necessary?

8 A Yes, there are some policies. They also use

9 InterQual.

10 Q Does the MDOC have a definition of medical

11 necessity?

12 A I don't think so, per se.

13 Q Has the standard of what meets medical necessity

14 changed at all over the course of your time working

15 in the Michigan prison system?

16 A Only in the sense that Uptodate changes every day.

17 Q All right. So what's the definition of medical

18 necessity that you apply?

19 A So, medical necessity is based on the medical

20 literature and the standard of care. So any

21 procedure, intervention, is based on the medical

22 evidence whether or not it's necessary.

23 Q What do you mean by "necessary"?

24 A So, you know, in medicine we have a saying, 'Do no

25 harm,' and if we order a test we want to make sure

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1 that that test will be the appropriate test and also  
2 be thinking that it may lead to other procedures, so  
3 want to make sure that it's the right type of  
4 imaging, for example. We want to make sure that  
5 the -- there are -- you know, everything in medicine  
6 we weigh the risk versus benefit. So the benefit of  
7 a treatment or a procedure should outweigh any risk,  
8 based on the medical evidence.

9 Q So if the benefit outweighs the risk is the  
10 procedure then medically necessary?

11 A No, that's only part of my answer.

12 Q That's only part of it? What else -- so you have to  
13 have benefit outweighing risk; what else do you  
14 need?

15 MR. SCARBER: I'm just going to place  
16 an objection; asked and answered in his last answer.  
17 He mentioned a number of things that go into it.

18 BY MR. CROSS:

19 Q You may answer.

20 A So, yeah, there are numerous research studies and  
21 FDA approvals, et cetera, to lead to the  
22 determination of medical necessity and benefit  
23 versus risk.

24 Q All right. So you're talking about efficacy and  
25 evidence-based medicine; is that right?

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1 A Correct.

2 Q So if there is research that indicates that the  
3 requested service, whatever it is, is effective for  
4 the condition, whatever it is, and the benefit of  
5 the service or procedure outweighs the risk, it is  
6 then medically necessary?

7 A You have to take it by -- patient by patient, you  
8 have to individualize this. You can't just make a  
9 blanket -- there are some generalizations, but you  
10 just can't just make a blanket statement.

11 Q Did you review any documents in preparation for  
12 today's deposition?

13 A Yes.

14 Q What documents did you review?

15 A I only reviewed documents provided by my attorney.

16 Q Did you review any medical records?

17 A I reviewed portions of medical records I was  
18 provided by my attorney.

19 Q Did you review medical records for an individual by  
20 the name of Kohchise Jackson?

21 A Yes.

22 Q What medical records did you review?

23 A There were excerpts from his chart, I believe; there  
24 was a 407 request.

25 Q What else?

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1 A I would have to have my attorney provide those  
2 documents again.

3 MR. SCARBER: Ian, we gave him the  
4 MDOC chart, he looked through that. I can't say he  
5 looked at every page, but he had that to skim  
6 through.

7 BY MR. CROSS:

8 Q All right. Did you receive any records about  
9 Mr. Jackson's treatment after he left the MDOC or  
10 before he entered the MDOC?

11 A I believe there was a document related to his time  
12 in a jail.

13 Q Okay. How about afterwards?

14 A I did not see any medical records afterwards, that I  
15 recall.

16 Q Have you ever met Mr. Jackson?

17 A No, with the caveat being that I do visit a lot of  
18 sites and do meet patients intermittently, but I  
19 can't say for sure.

20 Q Okay. But fair to say you've never evaluated him as  
21 a medical provider.

22 A No, I have not evaluated him.

23 Q Did you form any opinions about whether any  
24 procedures were medically necessary on the basis of  
25 your review of medical records for Mr. Jackson?

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1 A Yes, there was a request for revision of a

2 colostomy.

3 Q And you formed an opinion about whether reversing

4 that colostomy was medically necessary; is that

5 correct?

6 A Yes.

7 Q Based on your review of those medical records.

8 A Medical records and MDOC policy, yes.

9 Q Okay. So MDOC policy determines what's medically

10 necessary?

11 A No.

12 Q So, then, how did MDOC policy factor into your

13 clinical judgment about whether a colostomy reversal

14 was medically necessary?

15 A MDOC has policies based on medical necessity. They

16 don't do the research that determines medical

17 necessity, but their policies are based on medical

18 necessity.

19 Q Okay. But is it fair to say that you were able to

20 form an opinion about whether a colostomy reversal

21 was medically necessary or not based on reviewing

22 medical records?

23 A No, I would review Uptodate and see what the current

24 recommendation is, whether it's medically necessary.

25 Q So you looked at Uptodate and you looked at medical

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1 records?

2 A I have looked at Uptodate on a daily basis. I can't  
3 say that I looked at colostomy reversal in the last  
4 month, but I have reviewed that before.

5 Q Okay. But you were able to form an opinion on the  
6 basis of the medical records you reviewed in  
7 preparation for today's deposition and your  
8 experience and what you previously read on Uptodate?

9 A Yes.

10 Q Okay. So if I were to show you some medical records  
11 for Mr. Jackson from a time period after he was  
12 released from the Michigan Department of  
13 Corrections, would you be able to form a medical  
14 opinion about whether or not colostomy reversal was  
15 appropriate or medically necessary at that time?

16 A I can't say, I'd have to review the information.

17 Q And --

18 MR. SCARBER: Let me just place an  
19 objection to this line of questioning. This witness  
20 isn't a named defendant in this particular case.  
21 There is no allegations about whether this witness'  
22 medical judgment was involved in making the  
23 decisions in this particular case; and, you know,  
24 he's not really a part of the claim that's being  
25 made here.



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1 MR. CROSS: Is he going to testify  
2 about whether or not colostomy reversal is medically  
3 necessary?

4 MR. SCARBER: Are you talking about  
5 at the time that the request was made or are you  
6 talking about two-and-a-half years later?

7 MR. CROSS: I'm talking about at  
8 either time.

9 MR. SCARBER: If you're going to ask  
10 him the question, I suppose he could answer the  
11 question as to what was necessary at that particular  
12 time. But this is way outside the scope of what  
13 your claim is. And I don't want to go any further,  
14 you know, making any speaking objections, but my  
15 objection is that that's not what this witness is  
16 here for. He's not here to establish any standard  
17 of care testimony for your guy or your standard of  
18 care of testimony with respect to what happened  
19 later in the case with Dr. Weber or anything of that  
20 nature, if that's where you're going with it.

21 If you're going to ask him about the  
22 407 process, what was presented based upon what he's  
23 seen from the 407 process at that particular time in  
24 April of 2017 or that summer, based upon whatever  
25 was submitted or whatever the appeal or the

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1 grievance was, I mean, obviously, I think that's  
2 pertinent.

3 MR. CROSS: But you don't think it's  
4 pertinent to ask him about -- well --

5 MR. SCARBER: It doesn't matter if I  
6 think it's pertinent. I guess what I'm saying is  
7 that's my objection.

8 MR. CROSS: Okay.

9 MR. SCARBER: And I'll reserve it. I  
10 mean, you can ask him -- you certainly can -- if you  
11 got a question to ask, I'll make my objection as you  
12 ask it. I was just laying the foundation so that I  
13 didn't have to keep objecting to a whole bunch of  
14 questions that you might ask. But go ahead.

15 BY MR. CROSS:

16 Q Okay. So did you apply the same definition of  
17 medical necessity you just discussed when you were  
18 doing utilization review?

19 A Yes, the literature and the MDOC policy on  
20 revisions, I think, is very clear.

21 Q So who trained you to do utilization review?

22 A That would be my predecessor as state medical  
23 director, was Dr. Orlebeck.

24 Q And she taught you what constitutes medical  
25 necessity?

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1 A No.

2 Q No? Who taught you that?

3 A We use Uptodate, InterQual and other relevant  
4 medical literature to determine medical necessity.

5 Q So you look at the literature and if the literature  
6 indicates that a given treatment is, well, effective  
7 and the benefit outweighs the risk, is it then  
8 medically necessary or is there something else that  
9 you need?

10 A I would ask what is the consensus opinion, what does  
11 Uptodate say.

12 Q All right. Let me give you an example: Say a  
13 patient has cataracts, dense cataracts in both eyes;  
14 is it medically necessary to remove both cataracts  
15 or is it just good enough to remove one?

16 A I'd really have to know about the particular inmate  
17 and their symptoms. I'd have to have more details  
18 than that.

19 Q What details would you need?

20 MR. SCARBER: Just going to place an  
21 objection to asked and answered.

22 A I'd want to know more about the inmate, what's his  
23 vision, does he meet the medically necessary  
24 criteria.

25

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1 BY MR. CROSS:

2 Q So that's what I'm getting at here. What is the  
3 necessary medical criteria?

4 MR. SCARBER: Objection; asked and  
5 answered now quite a few times.

6 A About cataract removal, I would have to look it up.

7 BY MR. CROSS:

8 Q So there's a specific policy somewhere about  
9 cataract removal and when it's medically necessary  
10 to remove a cataract?

11 A No, consensus opinion and Uptodate, for example, is  
12 where I would look.

13 Q So you would look at Uptodate and see if Uptodate  
14 says do it, then you do it?

15 MR. SCARBER: Objection;  
16 mischaracterizes his testimony about -- I won't make  
17 a speaking objection. But he's already given you  
18 indications as to what might help his decision as to  
19 medical necessity.

20 A There are other guidelines. Medicare, I believe,  
21 has guidelines for cataract removal.

22 BY MR. CROSS:

23 Q So if something meets Medicare's guidelines, is  
24 it -- of medical necessity, is it then medically  
25 necessary, according to Corizon?

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1 A It's multifactorial. I'm just trying to explain  
2 that there's not just one thing that we look at, but  
3 Uptodate is our core resource.

4 Q All right. Is it possible that Corizon's definition  
5 of medical necessity is more restrictive than  
6 Medicare's?

7 A Wow. I couldn't really answer that. You're talking  
8 about a lot of information. I just really couldn't  
9 answer that.

10 Q Well, are there some procedures that Medicare would  
11 consider medically necessary and pay for that  
12 Corizon would not do for a prisoner?

13 A I can't answer that, there's just too many  
14 variables.

15 MR. CROSS: Why don't we take a break  
16 now.

17 THE VIDEOGRAPHER: Going off the  
18 record, the time is 12:33 p.m.

19 (Break was taken.)

20 THE VIDEOGRAPHER: We're back on the  
21 record. The time is 12:52 p.m.

22 BY MR. CROSS:

23 Q Okay. I'm going to take you back to Exhibit 6, this  
24 Utilization Management Manual, the portion about the  
25 UM core process. See where it says here, at the

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1 bottom, that some training will be provided to

2 support a successful launch?

3 A Yes.

4 Q Did you receive any training in connection with the

5 launch of the UM core process?

6 A Yes, we received training and we did review the

7 process.

8 Q All right. How was the training provided?

9 A I believe there was some live training, as well as

10 some virtual training.

11 Q Virtual training, interesting. How did you do the

12 virtual training?

13 A With -- actually, I think, Mignon, at one time, did

14 some training.

15 THE COURT REPORTER: Excuse me, what

16 was that?

17 A Yes, I did receive training, yes.

18 Q Okay. Did you -- were there any materials provided

19 to you during that training?

20 A I can't recall precisely what was provided, there

21 were some materials.

22 Q What kind of materials?

23 A I think there was an algorithm similar to the one

24 you showed me about -- it was focusing on the

25 process and procedure that is what happens to the

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1 407 once it's generated, who it goes to, and the  
2 appeal process. That's what the focus of that  
3 training was.

4 Q So was it this manual? Is that what you were shown?

5 A No, we weren't trained in this manual. There are  
6 parts of it, perhaps, but I didn't see this  
7 particular manual that you're showing me.

8 Q Okay. Did you go through a training module called  
9 RMD Utilization Management 101?

10 A I don't think so, no.

11 Q So the online training, was it live or was it  
12 recorded?

13 A There were --

14 MR. SCARBER: Just going to place an  
15 objection; I don't know if he said "online" or if he  
16 said "virtual." But go ahead.

17 A Yeah, no, it was live, either telephone or virtual.

18 BY MR. CROSS:

19 Q Do you know if that session was recorded?

20 A I do not.

21 Q Okay. And the in-person training, where did that  
22 take place?

23 A There was training at our annual state-wide meeting.

24 Q Who provided that training?

25 A I believe it was actually one of the VPs of

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1 operation and Mignon Ernst.

2 Q Did they give you any handouts or did they put up a

3 PowerPoint slide, any kind of the materials, or did

4 they just talk?

5 A There were materials. I don't have them.

6 Q Do you remember what they were?

7 A There were some -- there was a PowerPoint

8 presentation at the state-wide meeting.

9 Q Okay.

10 A And then there were subsequent calls, group calls.

11 Q Do you know what a 30(b)(6) witness is?

12 A I believe that is where you testify on behalf of a

13 corporation.

14 Q And you get specific subjects you're going to

15 testify about, correct?

16 A Correct.

17 Q And you have to become reasonably knowledgeable

18 about those subjects before you testify, correct?

19 A Correct.

20 Q Have you ever been a 30(b)(6) witness for Corizon?

21 A Yes, but, I'm sorry, sometimes the numbers or the

22 designations are confusing.

23 Q Were you ever designated to testify about Corizon's

24 document retention policies?

25 A I may have been asked a question about them. But I



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1 don't have anything to do with their document  
2 retention.

3 Q So you're not familiar with their document retention  
4 policies at all.

5 A No, I'm not a part of what happens at the corporate  
6 level.

7 Q Okay. Do you have a computer at work?

8 A Yes.

9 Q Do you need to retain documents that you create on  
10 your computer, pursuant to a policy?

11 A Pursuant to a policy. I had -- at one time, I had  
12 the MDOC policies and procedures and a copy of the  
13 contract. I do -- the Corizon forms, I do have the  
14 annual review form for providers on my computer.  
15 But I don't retain any documents for the company.

16 Q All right. Is there like a provider handbook or a  
17 manual that's provided to Corizon providers in  
18 Michigan?

19 A Yes.

20 Q Do you have access to that document?

21 A Yes, there are hard copies in the Lansing office.

22 Q And what's the title of it?

23 A Corizon Provider Training Manual?

24 Q Corizon Provider Training Manual? Okay. Is there a  
25 virtual version that providers can access online?

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1 A Not that I'm aware of. I have not.

2 Q Okay. I'm going to go back to this deposition you  
3 gave in Franklin. So here, at 15 through 16, you  
4 said, "The resources are now part of the onboarding  
5 manual which is available via the web to the  
6 providers." Do you have any idea what resources you  
7 were talking about there?

8 A I don't believe that ever materialized. That's what  
9 we were told was going to happen to it. But during  
10 my tenure, it actually did not.

11 Q And then at line 23 to 24, you were asked, "So it's  
12 an online manual now"? And you said, "Yes."

13 A Yes.

14 Q But, in fact, it was not actually an online manual?

15 A That was my understanding, that it was going to be  
16 online and was online, but it did not materialize.

17 Q Okay. So, in your opinion, is it medically  
18 necessary to reverse a functional colostomy, ever?

19 MR. SCARBER: Just going to place an  
20 objection to relevance, foundation. But go ahead.

21 A My opinion is based on medical necessity as per  
22 Uptodate and following MDOC policy. I'm not an  
23 expert in colostomies.

24 BY MR. CROSS:

25 Q Okay. What MDOC policy are you referring to, sir?

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1 A There is a policy that discusses cosmetic surgeries;  
2 and under their policy, colostomy reversal is  
3 considered more of a cosmetic procedure, and that is  
4 not approved.

5 Q So you're saying there's an MDOC policy that  
6 prohibits cosmetic surgeries; is that correct?

7 A Yes.

8 Q And under that policy a colostomy reversal is  
9 considered cosmetic.

10 A They refer to it as being part of a cosmetic group,  
11 yes.

12 Q What differentiates a cosmetic from a non-cosmetic  
13 surgical procedure?

14 A You'd have to ask the MDOC how they define that.  
15 But a cosmetic procedure is meant to reverse the way  
16 something looks.

17 Q Okay. So this policy that you're talking about,  
18 does it specifically say that colostomy reversals  
19 are cosmetic?

20 A I did see the policy prior to this deposition today,  
21 and it is present. Is it okay to refer to that  
22 policy?

23 Q Sure. Yeah.

24 A Do you want to bring it up or you want me to just  
25 to --

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1 Q I'll need a second to grab it. But I think I can

2 bring it up here. Let me find that policy. And you

3 have a copy in front of you?

4 A I do.

5 MR. SCARBER: We have one, Ian.

6 BY MR. CROSS:

7 Q Okay, let me just find it myself. What's the policy

8 number?

9 A It's Policy Directive No. 03.04.100.

10 Q All right, 03.04.100, and what version of the policy

11 are you referring to?

12 A The effective date is 2-1-2015, but this was

13 filed -- oh, no, that's an evidence number, right?

14 So, yeah, 2-1-2015.

15 Q All right. So we're looking at the same policy

16 right now.

17 A Okay.

18 Q What portion of the policy indicates that a

19 colostomy reversal is cosmetic?

20 A So they state under Section AA and BB, "Corrective

21 surgery is a surgical procedure to alter or adjust

22 body parts or the body's structure. Reconstructive

23 surgery is a surgical procedure to reform body

24 structure or correct defects. For purposes of this

25 policy, corrective and reconstructive surgery does

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1 not include procedures which can be done under local  
2 anesthesia. Corrective and reconstructive surgeries  
3 shall be authorized by a prisoner only if determined  
4 medically necessary and only if approved by the CMO.  
5 It shall not be approved if the sole purpose is to  
6 improve appearance."

7 Q Okay. So I don't see anything in that policy  
8 specifically about colostomy reversals. Can you  
9 explain how you believe that policy prohibits  
10 colostomy reversals.

11 A That's what we were told by the MDOC, that they  
12 consider colostomy reversals to be under this  
13 particular policy.

14 Q So is a colostomy reversal a reconstructive surgery  
15 or a corrective surgery?

16 A I -- again, I'm not an expert in interpreting that.  
17 It looks like the MDOC considers it a  
18 reconstructive-type surgery.

19 Q Okay. And does this policy say that corrective and  
20 reconstructive surgeries are not permitted for  
21 prisoners?

22 MR. SCARBER: Just going to place an  
23 objection; the policy speaks for itself, he didn't  
24 write the policy; and object to speculation as to  
25 what's meant by it, other than what the MDOC has

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1 already told the inmate. Go ahead, if you can

2 answer.

3 A It does state only if determined medically necessary

4 and only if approved by the chief medical officer,

5 which would be the chief medical officer of the

6 MDOC.

7 BY MR. CROSS:

8 Q In your time as a provider for the MDOC, are you

9 aware of any prisoners who received a surgery to

10 reform body structure or correct defects?

11 A Well, correcting defects can be interpreted much

12 more broadly in the face of an orthopedic injury,

13 for example, that affects function, which may be

14 medically necessary. So, in that context,

15 certainly.

16 Q Are you aware of any inmates who received a surgical

17 procedure to alter or adjust body parts during your

18 time as a provider?

19 A Not for cosmetic purposes, no.

20 Q Okay. So cosmetic purposes means what? The sole

21 purpose is to improve appearance?

22 MR. SCARBER: Just going to object to

23 form, and asked and answered already.

24 A That's what the policy says.

25

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1 BY MR. CROSS:

2 Q Do you think the sole purpose of reversing a  
3 colostomy is to improve appearance?

4 A I can tell you it's not considered medically  
5 necessary with -- according to Uptodate; and if it's  
6 not medically necessary, no, we don't approve them.

7 Q So do you think it was medically necessary in June  
8 of 2019 after Mr. Jackson got out of MDOC custody?

9 A I couldn't say. I don't have that information.

10 Q What information would you need?

11 A What was the patient presenting with, what was the  
12 opinion of the surgeon, what was the reasoning of  
13 it.

14 Q All right. I want to you assume, for the purposes  
15 of this question, that the patient's presentation at  
16 the time he received the surgery was the same in all  
17 material respects to his presentation when the  
18 surgical request was ATP'd while he was in the MDOC.

19 A So I don't understand what that presentation has to  
20 do with the policy that we were instructed to follow  
21 at the time.

22 Q It's not about the policy, sir, it's about what is  
23 medically necessary. So you're saying that the  
24 reversal surgery wasn't medically necessary because  
25 of the policy or because of the state of medical

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1 practice?

2 A That was not only the policy, that's, I believe,  
3 what even the patient's own surgeon said at the  
4 time.

5 Q Was it not medically necessary because of this  
6 policy or was it not medically necessary because of  
7 the state of medical practice?

8 MR. SCARBER: Just going to place an  
9 objection, asked and answered.

10 A Right, there's no evidence I'm aware of that says  
11 that it's medically necessary.

12 BY MR. CROSS:

13 Q So why isn't it medically necessary?

14 MR. SCARBER: Just place an objection  
15 to asked and answered, now quite a few times, again.

16 A Well, we'd had have to go and look at all the  
17 literature that resulted in that consensus opinion.  
18 So it would be a number of reasons it's considered  
19 not necessary.

20 BY MR. CROSS:

21 Q Are you aware that the colostomy was eventually  
22 reversed?

23 A Yes.

24 Q So do you think that -- hold on. Strike that. Are  
25 you aware that the Michigan Medicaid program was



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1 billed for the cost of the reversal surgery?

2 A No.

3 Q All right. Well, I want to you just assume that

4 it's true. Are you aware that medical necessity is

5 a condition of payment under both the Medicare and

6 the Michigan Medicaid programs?

7 A I've not seen the language.

8 Q Are you aware that a physician who directly or

9 indirectly seeks reimbursement from Michigan

10 Medicaid for a service that is not medically

11 necessary is committing healthcare fraud, a ten-year

12 felony?

13 A As you say.

14 Q So do you think Dr. Weber, the doctor who reversed

15 Mr. Jackson's colostomy shortly after he was

16 released from prison, committed healthcare fraud?

17 A I cannot speak to the specifics of that case.

18 Q So, the way I see it, there are three possibilities

19 here: Either, one, his condition changed between

20 the time he was in prison and the time that he was

21 released such that, while it wasn't medically

22 necessary when he was in prison, it became medically

23 necessary when he was released; or Dr. Weber

24 committed healthcare fraud by performing a procedure

25 and billing for a procedure that's not medically

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1 necessary; or Corizon's definition or the MDOC's  
2 definition of medical necessity is different from  
3 the definition used by the Michigan Medicaid  
4 program. Can you think of another possibility?

5 MR. SCARBER: I'm just going to place  
6 an objection to the form of the question and to  
7 speculation all over the question. Your question  
8 started out even with speculation on your behalf.  
9 So object to form, speculation. He can't answer  
10 that kind of question. But go ahead, if you can.

11 A I can't, there's too many variables. There's always  
12 a difference of opinion among medical providers.  
13 But I can't speak to the legalities of whether they  
14 committed a crime or fraud.

15 BY MR. CROSS:

16 Q Well, do you think it was medically necessary to  
17 reverse the colostomy after he got out if we assume  
18 that his condition was the same?

19 MR. SCARBER: Objection; asked and  
20 answered, calls for speculation, foundation.

21 A Again, you're asking me to speculate. I don't know.

22 BY MR. CROSS:

23 Q Well, what kind of information would you need to  
24 know?

25 A I'd want to see the surgeon's note prior to the

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1 procedure, the nature of the procedure, what  
2 procedure was done; and even then, I mean, you're  
3 going to find difference of opinion among different  
4 surgeons. His previous surgeon, I understand, said  
5 it wasn't medically necessary.

6 Q Well, would it help you if I showed you the  
7 surgeon's note prior to the procedure? Would you be  
8 able to form an opinion then?

9 A Again, you're asking me to speculate?

10 Q Well --

11 A I can't do that.

12 Q -- didn't you testify earlier that you formed an  
13 opinion about whether a colostomy reversal was  
14 medically necessary for Mr. Jackson based on your  
15 review of some medical records in preparation for  
16 today's deposition?

17 MR. SCARBER: I'm going to place an  
18 objection; that mischaracterizes his testimony. And  
19 I don't want to make a speaking objection, but a lot  
20 more went into that answer.

21 A I believe I answered as to medical necessity and how  
22 that MDOC policy dictated what they would approve  
23 and what they would not.

24 BY MR. CROSS:

25 Q So you didn't have an opinion as to whether the

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1 reversal surgery was medically necessary in April of  
2 2017.

3 MR. SCARBER: You mean did he  
4 formulate an opinion in April of 2017?

5 MR. CROSS: No, I'm asking him does  
6 he have an opinion today that he was able to  
7 formulate, based on reviewing medical records from  
8 Mr. Jackson's time in the MDOC, about whether or not  
9 a colostomy reversal was medically necessary for  
10 Mr. Jackson.

11 MR. SCARBER: And I'm going to  
12 object, again, that it's been asked and answered  
13 repeatedly about what he thinks about that  
14 particular procedure, whether it should have been  
15 done or whether it was medically necessary or what  
16 the basis of his opinion already was concerning  
17 that. But I think the record will speak for itself  
18 that he's been asked that a number of times and  
19 given reasons as to his opinion. But go ahead.

20 A No, it did not meet the criteria for medical  
21 necessity.

22 BY MR. CROSS:

23 Q So why couldn't you determine, based on medical  
24 records from June of 2019, whether it met criteria  
25 for medical necessity at that time?

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1 MR. SCARBER: I'm just going to place  
2 app objection, also, to, at this point, what  
3 difference does it make for this doctor, at this  
4 point, to be talking about something that happened  
5 well after this time period. But go ahead. He  
6 didn't make any decisions -- but go ahead.

7 A Yes, the decision would be the same based on the  
8 policy.

9 BY MR. CROSS:

10 Q The decision would be the same based on the policy,  
11 meaning, in June of '19, the decision would be the  
12 same?

13 A Unless this policy has been changed, yes.

14 Q Okay. So the determination of whether it's  
15 medically necessary or not is based on a policy of  
16 the MDOC.

17 MR. SCARBER: Objection; asked and  
18 answered, many times, and taken out of context of  
19 what his prior testimony was.

20 A So, again, my answer is the same, the MDOC base  
21 their policy on medical necessity.

22 BY MR. CROSS:

23 Q Is it possible that medical necessity in the MDOC  
24 context is different from medical necessity in the  
25 Michigan Medicaid program context?

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1 MR. SCARBER: I'm going to place an  
2 objection; calls for speculation. The question  
3 itself asked him is it possible; anything is  
4 possible. But if you can answer.

5 A It's possible, but I don't have those Medicaid  
6 policies in my hands for review.

7 (Bomber Deposition Exhibit No. 10 was  
8 marked for identification.)

9 BY MR. CROSS:

10 Q Okay. Let me show you a document. We'll call this  
11 Exhibit 10. This is a declaration of Dr. Erin  
12 Orlebecke, and I believe you testified earlier that  
13 Dr. Erin Orlebecke trained you how to do utilization  
14 management activities; is that correct, sir?

15 A Yes.

16 Q And she was the state medical director before you  
17 were the state medical director; is that correct?

18 A Yes.

19 Q Okay. Now, down here on page six of the  
20 declaration, if we look at the bottom of No. 13, it  
21 says, "If a patient can hear out of one ear without  
22 a hearing aid, then no hearing aid is necessary for  
23 the other ear." Do you agree with that?

24 MR. SCARBER: I'll just place an  
25 objection, before the witness answers, as to we

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1 don't know anything about this particular case at  
2 this point, what this is referring to, what the  
3 facts are, and what this doctor was actually  
4 responding to. But if you can answer, go ahead.

5 A I believe that the MDOC did have policies on hearing  
6 aid and replacement and what the criteria were for  
7 approval of hearing aids; that has changed  
8 throughout the years. So, at the time -- and Dr.  
9 Orlebecke didn't train me, per se, on this  
10 particular patient, but there was a policy at the  
11 time that we would follow.

12 BY MR. CROSS:

13 Q Do you know a Dr. Harriet Squier?

14 A Yes.

15 (Bomber Deposition Exhibit No. 11 was  
16 marked for identification.)

17 Q Okay. I'm going to show you what's been marked  
18 Plaintiff's Exhibit 11. This is a declaration of  
19 Dr. Harriet Squier, and here, at page six, she says,  
20 "Mr. Coates's examination suggested that he had very  
21 good hearing in the right ear; therefore, a hearing  
22 aid in the other ear would not add much benefit and  
23 there was no medical necessity for Mr. Coates to  
24 have a hearing aid."

25 Do you agree that there's no medical

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1 necessity to have a hearing aid in one ear if you

2 can hear out of the other ear?

3 MR. SCARBUR: Same objection as

4 before, but go ahead, with respect to the affidavit

5 by -- or declaration by Dr. Orlebecke. But go

6 ahead, so I don't have to repeat it, go ahead.

7 A I would have to know what Uptodate said at the time,

8 as well as the MDOC policy.

9 BY MR. CROSS:

10 Q Okay. Do you know what Dr. Squier's job was when

11 she worked in the MDOC?

12 A Yes, she worked for PHS, which became Corizon, as a

13 utilization management physician.

14 Q And you started doing utilization management at the

15 point that she retired; is that correct?

16 A Yes, I believe that was around the time I left.

17 Q And then who took over from you?

18 A Dr. Papendick replaced Dr. Squier.

19 Q Okay. So, fair to say, at some point in, you know,

20 2012 to 2014, it was not considered medically

21 necessary for a prisoner to hear out of both ears?

22 MR. SCARBUR: I'm going to place an

23 objection. He has already said he would have to

24 review a policy -- objection; calls for speculation,

25 foundation. Go ahead.



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1 A Yeah, I'm sure that, at the time, Uptodate and MDOC  
2 policy spelled out what type of hearing loss  
3 required corrective aids, but I don't remember the  
4 details.

5 BY MR. CROSS:

6 Q Is there a risk of death associated with getting a  
7 hearing aid?

8 A Not that I'm aware.

9 Q Okay. Are there some benefits to being able to hear  
10 out of both of your ears?

11 MR. SCARBER: Just going to place an  
12 objection to relevance as well. Go ahead. It has  
13 nothing to do with the medical issue we're talking  
14 about here. But go ahead.

15 A Yes, it's better if you have hearing from both of  
16 your ears.

17 BY MR. CROSS:

18 Q Okay. So, from the patient's perspective, is it  
19 possible that the benefits of a hearing aid outweigh  
20 the risks?

21 A It's possible.

22 Q Okay. So, do you think the utilization management  
23 department is considering something else besides the  
24 risks versus the benefits to a patient of a  
25 particular procedure?

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1 MR. SCARBER: Calls for speculation.

2 He wasn't involved in any of those cases. But go

3 ahead.

4 A No, I wasn't involved in determining that policy.

5 But I know that it was a joint process between

6 Corizon and the DOC.

7 BY MR. CROSS:

8 Q Can you answer the question that I asked you, sir?

9 A Can you repeat the question.

10 MR. CROSS: Ms. Hicks, can you repeat

11 that question.

12 (Page 88, lines 22-25 were read

13 back.)

14 A Can you tell me what "something else" means?

15 Q Well, I'm asking you that, sir. Are they

16 considering something besides a risk-to-benefit

17 analysis?

18 A Well, they're considering what the MDOC thinks about

19 the issue, as well, and what their policy is.

20 Q Okay. You talked before about Uptodate and the need

21 to establish that the treatment -- that there's

22 evidence to support the treatment, right? That's

23 part of medical necessity?

24 A Correct.

25 Q Do you know if there's evidence that hearing aids

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1 help with hearing loss?

2 MR. SCARBER: I'll place another  
3 objection to relevance, particularly with respect to  
4 this issue. It has nothing to do with the Monell  
5 claim that we're talking about here or possible  
6 Monell claim. Go ahead.

7 A I would have to read up on the benefits of hearing  
8 aids. Sorry, I don't know off the top of my head.

9 BY MR. CROSS:

10 Q So I'm just -- it seems to me like there's something  
11 else being considered besides a risk/benefit  
12 analysis and whether the procedure is supported by  
13 evidence, at least in this case with the hearing  
14 aide. Do you agree with that?

15 A Not that I'm aware of, no.

16 Q So those are the only things that are being  
17 considered, is whether it's A1 evidence that the  
18 procedure helps the problem and the risks to the  
19 patient and the potential benefits to the patient?

20 MR. SCARBER: Just going to place an  
21 objection, asked and answered. Go ahead.

22 A That's how I practice medicine, yes.

23 BY MR. CROSS:

24 Q You practice outside of a prison as well, correct?

25 A Yes.

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1 Q Do you look at MDOC policies when determining  
2 whether a given test or procedure is medically  
3 necessary for your non-prisoner patients?

4 MR. SCARBER: I'm just going to place  
5 an objection to relevance. We're not talking about  
6 what this particular doctor does outside of what's  
7 involved in the treatment of Mr. Jackson, who, at  
8 the time of his lawsuit, was an inmate in the county  
9 jail, as well as a prisoner in the Michigan  
10 Department of Corrections. So we're not -- it's  
11 irrelevant to the issue in this case. Go ahead.

12 A I do not use MDOC policy outside of the MDOC.

13 BY MR. CROSS:

14 Q So are there things that might be medically  
15 necessary outside of the MDOC that wouldn't be  
16 medically necessary inside the MDOC?

17 A It just so happens that what I use out in the world  
18 is Uptodate, it's very similar.

19 Q But Uptodate is not the only thing you use inside  
20 the MDOC, right?

21 MR. SCARBER: Asked and answered.

22 But go ahead.

23 A No, they also use InterQual, National Cancer  
24 Coalition data, and then sometimes a literature  
25 search is done, too, to see if there's anything new

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1 and current.

2 MR. CROSS: All right. I don't have  
3 further questions. Thank you for your time, sir.

4 MR. WILLIS: I don't have anything.

5 EXAMINATION

6 BY MR. SCARBER:

7 Q Doctor, I have one question for you. Specifically,  
8 when you were talking about the appeals procedure  
9 with respect to a final determination as to whether  
10 or not Mr. Jackson would have a colostomy reversal  
11 or not, who has the -- who makes the final  
12 determination as to whether or not that procedure  
13 would be done?

14 A The final determination is made by the chief medical  
15 officer of the Michigan Department of Corrections.

16 Q Corizon is not the final decision-maker with respect  
17 to that procedure?

18 A That's correct, Corizon is not.

19 MR. SCARBER: I don't have anything  
20 further.

21 MR. CROSS: I have some follow-up.

22 EXAMINATION

23 BY MR. CROSS:

24 Q Does Corizon have any policies about what is  
25 medically necessary?

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1 A No, because we're told -- we're instructed to use  
2 Uptodate. They have clinical modules -- I mentioned  
3 that earlier -- for diabetes, hypertension, prostate  
4 cancer. But they're just modules based on the  
5 evidence, and, on a day-to-day basis, we're  
6 instructed to use Uptodate. Corizon pays for that  
7 for all of its providers.

8 Q Well, does Corizon instruct its providers at all  
9 about what's medically necessary and what's not  
10 medically necessary?

11 A Yeah, based on what's in Uptodate and what the  
12 policies of the MDOC are. But there's no Corizon  
13 policy saying, 'Hey, you need to approve this for  
14 this and not this.' There's nothing like that.

15 Q Let's go back to the exhibit we talked about before,  
16 "Practitioner Clinical Onboarding"; and one of the  
17 modules here under "Utilization Management" is  
18 called "Determining Medical Necessity"; and did you  
19 testify that you provide that training?

20 MR. SCARBER: Hey, Ian, you've got  
21 the wrong exhibit up, I'm sorry.

22 MR. CROSS: What do I have up?

23 MR. SCARBER: You got a declaration  
24 up. Just maybe go back a few.

25 MR. CROSS: Hold on.

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1 MR. SCARBER: While you're getting  
2 it, I'm just going to note this is -- I thought this  
3 wasn't, but now it's clear that this is outside the  
4 scope of what I had asked the witness in my one  
5 question. So it's outside the scope of my direct of  
6 the witness. But go ahead.

7 BY MR. CROSS:

8 Q You train people about that, determining medical  
9 necessity?

10 MR. SCARBER: Place an objection,  
11 asked and answered, about maybe an hour-and-a-half  
12 or so ago. But go ahead.

13 MR. CROSS: Yeah, I don't remember  
14 what he said.

15 MR. SCARBER: Okay.

16 A Sure. The answer is that yes, we direct them to  
17 Uptodate and the other resources available for  
18 medical decision-making.

19 BY MR. CROSS:

20 Q And so all you tell them to do to determine medical  
21 necessity is look at Uptodate?

22 A Uptodate, National Cancer.

23 Q Cancer.

24 A The same. There's no Corizon policy like that.

25 We're using Uptodate 'cause it's current

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1 information, it's dynamic.

2 Q Okay.

3 MR. SCARBER: And let me just place  
4 another objection to all -- he's already answered  
5 all of the various things that go into determining  
6 medical necessity for a particular patient in his  
7 testimony over the last couple of hours. But go  
8 ahead.

9 BY MR. CROSS:

10 Q Your testimony is that there's no Corizon definition  
11 of medical necessity anywhere that's given to the  
12 providers?

13 A Not -- when I train my providers, I show them  
14 Uptodate, we review it, there are -- there's no,  
15 something similar to Uptodate, that Corizon has that  
16 I'm aware of.

17 In the training manual, there are a  
18 couple statements about medical necessity. But  
19 there's no, like, algorithm or rules for making a  
20 decision inside Corizon outside of that. So, no,  
21 I'm not sure what, you know --

22 Q But there's something in the training manual about  
23 determining medical necessity.

24 A Yeah, there are some guidelines.

25 MR. CROSS: Okay. Thanks. That's



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1 all I have.

2 EXAMINATION

3 BY MR. SCARBER:

4 Q With respect to whether there are guidelines in the

5 training manual determining medical necessity or

6 not, is there any specific direction or order that

7 Corizon gives to its medical providers or reviewers

8 limiting their ability at all -- and I'm not talking

9 about MDOC policy, but I'm talking about something

10 from Corizon -- limiting their ability to be able to

11 factor in the things that they feel are important

12 for medical necessity?

13 A No, quite the contrary; in fact, we tell them if you

14 find something outside of Uptodate in the medical

15 literature -- for example, sometimes new things came

16 out in "The New England Journal" or "The Journal of

17 American Medicine" that Uptodate was a little behind

18 on -- and we considered that information as well.

19 So, no, they're never limited.

20 Q And is the patient's presenting condition and

21 symptoms something that is also very important in

22 determining whether something is medically necessary

23 for that particular patient?

24 A Yes.

25 Q And if the patient, in this particular situation,

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1 has a functional colostomy and no complaints of  
2 physical issues or pain or any type of suffering  
3 related to that particular colostomy, would that be  
4 something that would be considered in determining  
5 whether it was medically necessary?

6 A Yes.

7 Q In addition to all of the other factors that you  
8 already spent time discussing here.

9 A Correct.

10 Q Again, these are factors; is that correct?

11 A Yes, sir.

12 MR. SCARBER: I have nothing further.

13 EXAMINATION

14 BY MR. CROSS:

15 Q Doctor, do you have an understanding of what  
16 prisoners are entitled to under the Eighth Amendment  
17 in terms of health care?

18 MR. SCARBER: All right, I'm going to  
19 place an objection; that's way outside of the scope  
20 of my redirect at this point. So what do you want  
21 to do?

22 MR. CROSS: Are you going to instruct  
23 him not to answer?

24 MR. SCARBER: I'm going to place a  
25 very, very strong limit on what we discuss after

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1 this point, if you got one question or something  
2 like that, but now this is going in a whole other  
3 direction. This is not follow-up. This is stuff  
4 that could have been covered on your direct or  
5 cross. Go ahead.

6 A It's been some time since I've read the Eighth  
7 Amendment. But the bottom line is inmates are  
8 entitled to the same standard of care as that as  
9 available in the community. So I'd have to go back  
10 and look at the Eighth Amendment.

11 MR. SCARBER: And I'm going to place  
12 an objection that it calls for a legal conclusion.

13 BY MR. CROSS:

14 Q Okay. Now, Devlin, your attorney just asked you  
15 some questions about the factors that Corizon  
16 providers consider when they are determining whether  
17 a colostomy reversal is medically necessary, like is  
18 the patient in pain or having issues with the  
19 colostomy. Are those the same things that a  
20 provider would consider in the community when  
21 determining whether a colostomy reversal is  
22 medically necessary?

23 MR. SCARBER: Place an objection to  
24 foundation. But go ahead.

25 A Yes.

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1 BY MR. CROSS:

2 Q So if you were at a community hospital and someone  
3 came in with a functional colostomy, you would say,  
4 'I'm not going to refer you to a surgeon because you  
5 don't need this to be reversed'?

6 A I definitely would explain the medical necessity and  
7 the risks versus benefits of any procedure.

8 Q But would you refer them to a general surgeon or no?

9 A Yeah, if a patient came to me requesting -- any  
10 procedure, really -- and if they were adamant that  
11 they wanted to see a specialist, absolutely I would  
12 facilitate that.

13 MR. CROSS: Okay. I don't have any  
14 further questions. Thank you, sir.

15 MR. SCARBER: I have a follow-up  
16 question.

17 EXAMINATION

18 BY MR. SCARBER:

19 Q Is it true that Mr. Jackson was incarcerated at the  
20 time of this particular event that he's talking  
21 about, his colostomy reversal request?

22 A Yes.

23 Q Mr. Jackson was not on the -- in the outside  
24 community, was he?

25 A Not at that time.

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1 Q Were there any specific -- and I think you've  
2 already testified -- but there was not an MDOC  
3 policy involved in that particular determination as  
4 to when he was on the outside of the medical  
5 community?

6 A I don't believe so.

7 Q I'm sorry, on the outside of the Department of  
8 Corrections.

9 A No.

10 Q And you testified earlier about your understanding  
11 of the Eighth Amendment. Were you speculating about  
12 the Eighth Amendment and what the legal requirements  
13 were?

14 A It's been a long day and I'm just drawing a blank  
15 there.

16 Q All right. Do you have an understanding that under  
17 the Eighth Amendment Mr. Jackson would have to  
18 demonstrate a serious medical need for a particular  
19 procedure?

20 A Thank you for reminding me; yes.

21 Q Would it also be your understanding that he would  
22 have to have a serious medical need that was  
23 willfully ignored or disregarded by a healthcare  
24 professional that caused him some kind of harm,  
25 substantial harm, with respect to whether or not a

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1 procedure was done?

2 A Yes, thank you, that's what I recall now.

3 Q Are you aware, from any records that you've

4 reviewed, of seeing a serious medical need for a

5 colostomy reversal demonstrated, by Mr. Jackson in

6 this particular case, during the time of his

7 incarceration in the MDOC?

8 A I am not.

9 Q Have you been advised of any serious physical harm

10 or pain or suffering in any physical manner that was

11 experienced by Mr. Jackson as a result of not

12 getting a colostomy reversal in the MDOC?

13 A I am not.

14 MR. SCARBER: I have nothing further.

15 MR. CROSS: All right. I don't have

16 anything further.

17 MR. WILLIS: Nothing for me. Thank

18 you.

19 THE VIDEOGRAPHER: This concludes the

20 deposition. The time is 1:40 p.m.

21 (The virtual, videotaped deposition

22 concluded at 1:40 p.m.)

23

24

25

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1 CERTIFICATE OF NOTARY

2 STATE OF MICHIGAN )

3 ) SS

4 COUNTY OF LIVINGSTON )

5 I, Carol Marie Hicks, Certified Shorthand Reporter,

6 a Notary Public in and for the above county and state, do

7 hereby certify that the above deposition was taken before

8 me at the time and place hereinbefore set forth; that the

9 witness was by me first duly sworn to testify to the

10 truth, and nothing but the truth, that the foregoing

11 questions and answers made by the witness were duly

12 recorded by me stenographically and reduced to computer

13 transcription; that this is a true, full and correct

14 transcript of my stenographic notes so taken; and that I

15 am not related to, nor of counsel to either party nor

16 interested in the event of this cause.

17

18

19

20 Carol Marie Hicks

21 CSR 3345 Notary Public,

22 Livingston County, Michigan

23 My Commission expires: September 4, 2021

24

25

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